Article 12 – SHARE OF COST

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12A -- RECORD OF HEALTH CARE COSTS -- SHARE OF COST (SOC) (FORM MC 177S) PROCESSING

1. Background

The Record of Health Care Costs — Share of Cost, forms MC 177S-M and MC 177SA-M (MC 177S), are designed to accommodate the automated SOC claims process administered by Computer Sciences Corporation (CSC). The MC 177S is used to list health care services rendered by a provider to beneficiaries with an SOC. The MC 177S is forwarded by the county welfare departments to the Department of Health Services (DHS) for certification and Medi-Cal card issuance. Subsequently, the MC 177S is forwarded to the fiscal intermediaries to be used in the processing of provider claims.

Data Systems Branch, Key Data Entry Unit, is currently responsible for certifying most medically needy and medically indigent persons with an SOC.

2. County Review of MC 177 Forms

Section 50658 explains the county's responsibility for review of the signed MC 177S form.

Information from the MC 177S is entered on the Medi-Cal Eligibility Data System (MEDS) and, therefore, must match the corresponding MEDS data fields. Likewise, information from the MC 177S is entered into the fiscal intermediary claims processing system. All data on the MC 177S form must be filled out accurately and completely. The following information must be entered for each eligible member of the Medi-Cal Family Budget Unit (MFBU). It should be printed or typed and must be clear and legible:

a. Fourteen-digit Medi-Cal ID number (each ID number must have a different person's number).

b. Name (last name first on the MC 177S documents).

c. Birth date (month/day/year).

d. Sex.

e. Valid one-digit Other Coverage code, if applicable.

f. Social Security number.

g. Health Insurance Claim or Railroad Retirement number.

(See "Instructions — Record of Health Care Costs — Share of Cost" in the forms portion for complete preparation instructions.)

The following information must be entered for each ineligible member of the MFBU:

a. State number — Use either "I.E." or "00" in the aid code field to designate an ineligible person to ensure that a Medi-Cal card is not issued for this person.

b. Name.

c. Birth date (month/day/year).

d. Sex.

(NOTE: Persons who are excluded from the MFBU must not be listed on the MC 177S.)

Each provider entry must contain the following:

a. Services or supplies which were provided during the specified month only.

b. Medi-Cal provider number or license number (if not a Medi-Cal provider).

c. The 14-digit state number ("Patient's Medi-Cal ID Number") assigned to the beneficiary or the number assigned to persons designated as ineligibles to whom services are being rendered.

d. The exact date (month, day, year) each service was provided ("Service Dates"). Indicate from and through dates.

e. The procedure/drug code ("Procedure/Drug Code"). Each procedure/drug code rendered to the SOC beneficiary must be entered by line item. For example, if the beneficiary receives three prescriptions, each prescription must be entered separately on the MC 177S.

f. The amount obligated or paid by the beneficiary.

g. Provider name.

h. Provider signature. The signature must be that of the provider or a facility representative. (Stamped provider signatures are not acceptable unless initialed by the provider or facility representative.)

i. The specific Medi-Cal service rendered ("Service Description").

In those situations where a provider is unwilling to complete his/her portion of the MC 177S due to workload, inconvenience, or neglect, the following exception process will be acceptable:

a. The beneficiary shall submit a copy of the bill along with the beneficiary's signature on the MC 177S to the county welfare department.

b. The bill shall indicate the following: patient's name, date, type of service, total amount due, and the amount billed to the beneficiary.

This procedure shall only be used when the provider is unwilling to complete the MC 177S. The county shall complete the MC 177S entry except for the provider signature and submit the MC 177S to DHS, together with a note explaining that the provider was unwilling to complete the MC 177S.

3. **County Submission of Forms**

The county shall submit the original MC 177S to DHS when the SOC has been met and the form signed. The completed MC 177S should be sent to:

Department of Health Services
Information Technology Services Division
ATTN: Key Entry Unit
1615 Capitol Avenue, MS 6303
Sacramento, CA 95814

4. **Certification Processing**

Certification by Key Data Entry Unit is the formal process of confirming that beneficiaries are entitled to Medi-Cal benefits within an eligible period. Certification requires review of the MC 177S to:

a. Ensure that the assigned SOC has been obligated or paid.

b. Ensure that only medical costs for appropriate persons have been used to meet the SOC.

c. Determine the certification date, i.e., date on which the beneficiaries met their SOC. Services billed to Medi-Cal for dates prior to the certification date must be reviewed to determine if those services were used to meet the SOC and therefore are not payable by Medi-Cal.

5. Computerized Verification Procedures

Key Data Entry will attempt to certify each eligible MFBU member listed on the MC 177S on MEDS. All MC 177S documents which fail MEDS edits will be returned to the appropriate county welfare department for correction, along with a copy of the MEDS 5.1.1.1. report (see page 12A-5). The report lists the information entered on the transaction, the conflicting data field contents, and the error message for each transaction. Key Data Entry Unit will review the error reports to ensure that the reject is not due to key entry error prior to returning the reports to the county. The records of family members which were accepted for card issuance will be lined out on the MC 177S. Report entries requiring no county action will be crossed out.

The Notification of Discrepancy, form DHS 2208 (see page 12A-6), will be used when no MEDS report is available; for example, for transactions rejected on on-line edits or when erroneous entries or omissions are identified prior to key entry.

If either a DHS 2208 or a MEDS error report is received with an MC 177S, counties should take prompt action to correct the MC 177S and/or MEDS, as appropriate, and return the MC 177S to the State as soon as possible. In addition, if the county is aware of any reason an SOC case cannot be certified on MEDS, a note should be attached to the MC 177S so that certification will not be attempted on MEDS. For example, MEDS does not allow a change from a non-SOC aid code to an SOC aid code in the same month. Therefore, the following note should be attached to the MC 177S: "Do not attempt to certify this case through MEDS, process through CID." In this example, the State will generate the card(s) through another system (CID).

6. Card Issuance

DHS will issue Medi-Cal cards via MEDS (or CID as noted above) to each beneficiary who is certified as eligible. Routine processing requires one to two weeks after DHS receives the MC 177S from the county. If the county receives inquiries from the beneficiary or from providers after the two weeks, county staff should query the MEDS Full Status Inquiry screen to see if a card was recently issued. Since Key Data Entry Unit is unable to respond to telephone inquiries regarding the status of MC 177S processing, counties may certify the case, using copy of the MC 177S in case file, and issue an immediate need Medi-Cal card per Article 12B.

Eligibility Branch will issue a SYSM message if backlogs develop and MC 177S processing requires more than two weeks.

STATE OF CALIFORNIA — DEPARTMENT OF HEALTH — MEDI-CAL ELIGIBILITY DATA SYSTEM — PAGE 2

REPORT NO 5.1.1.1 — REPORT DATE 04/06/84 — .....TITLE..... STATE WORKER ALERT — .....COUNTY..... FRESNO

CASE NAME		PERSON NAME		BIRTHDATE	COUNTY ID	MEDS ID	
[redacted]ON	,DANI	[redacted]ON	DANIEL	09/21/946	10-57-04[redacted]87-0-01	540-60-[redacted]R1	

SOURCE	TRANS	DATE	DATA FIELD.....	DATA FIELD CONTENTS.....	MESSAGE.....	STATUS..
ZUHN	BR30	04/04/84	0412 AID-CODE PEB	30	4206 SOC CERT INVALID FOR RECIPIENT WITH NO SOC ON FILE	REJECT
			0432 ELIG-STAT PEB	001		

CASE NAME		PERSON NAME		BIRTHDATE	COUNTY ID	MEDS ID	
JE[redacted]MS	,JESS	JE[redacted]MS	JESSIE	03/31/918	10-17-04[redacted]69-0-02	540-20-[redacted]R1	

SOURCE	TRANS	DATE	DATA FIELD.....	DATA FIELD CONTENTS.....	MESSAGE.....	STATUS..
ZUHN	BR30	04/04/84	0433 ELIG-STAT MAR	999	4206 RECIPIENT NOT ELIGIBLE ON MEDS FOR CERTIFICATION MONTH	REJECT

MEDS 5.1.1.1 REPORT

State of California—Health and Welfare Agency — Department of Health Services

NOTIFICATION OF DISCREPANCY
Record of Health Care Costs

County/District Code _____

The attached Record of Health Care Costs (MC 177) is being returned to you for the reason(s) checked below. Please return this form when resubmitting the Record of Health Care Costs

☐ 1. MC 177/MEDS (Medical Eligibility Data System) Discrepancy on item(s) checked or see comments:

- ☐ County
- ☐ State No.
- ☐ Aid Code
- ☐ FBU No.
- ☐ Person No.
- ☐ Name
- ☐ Birthdate
- ☐ Other Coverage Code
- ☐ Social Security No.
- ☐ Address
- ☐ City
- ☐ Zip Code
- ☐ Medical Expense Month
- ☐ Share of Cost Amount
- ☐ Hospitalization Through Date
- ☐ Incorrect Form Submitted (submit CSC and Dent-Cal Copies Only)

☐ Other Discrepancies/Comments _____

☐ 2. Provider did not complete the following on the MC 177:

- ☐ Provider Medi-Cal Number
- ☐ Patient Medi-Cal Number (State Number)
- ☐ Service Dates
- ☐ Billed Patient
- ☐ Total Bill
- ☐ Provider Name
- ☐ Provider Signature
- ☐ Service Description
- ☐ Procedure/Drug Code

☐ 3. MEDS conflict, unable to certify the individuals with a check mark in the left margin, please verify all items on that line.

☐ 4. Systems Support Section processes Long-Term Care (LTC) cases when the share of cost exceeds the facility's Medi-Cal reimbursement rate (usually $1,000 or over) or when there is a spenddown of property. All other LTC cases are processed through MEDS/CID (Central Issuance Distribution).

☐ 5. SHARE OF COST NOT MET. Services listed are not within the month/year of eligibility. Amounts used to meet share of cost must be listed in the Billed Patient column and total the share of cost amount.

☐ 6. MEDS System shows no eligibility for the case/individual. Person(s) No. _____ must be added to MEDS for the month indicated before certification can be completed.

☐ 7. Comments: _____

_____

_____

Verifier's Initials _____

Date _____

DHS 2204 (9/85)

12B — COUNTY CERTIFICATION AND MEDI-CAL CARD ISSUANCE FOR ELIGIBLES WITH A SHARE OF COST (SOC)

The following procedures are to be used when issuing an immediate need SOC Medi-Cal card, either via the Medi-Cal Eligibility Data System (MEDS) or manually.

1. Client's Certification of Medical Need

   Medi-Cal beneficiaries who have returned a completed and signed Record of Health Costs — Share of Cost (MC 177S) showing they have met their SOC may request the county department to issue an immediate need Medi-Cal card. To receive an immediate need card, the eligible person must certify, on the Medi-Cal Card/POE Label Request (MC 110), that he/she requires the card in order to receive needed services between the date of request and normally expected receipt date of a card issued by the Department of Health Services (DHS).

   Original MC 110 forms should be retained by the county.

2. Certification Processing by the County

   Once the beneficiary signs the MC 110, the county department shall review the MC 177S and certify the following:

   a. The case description portion of the form is complete (name, Medi-Cal ID number, etc.).

   b. The "Patient Medi-Cal ID Number" in each line entry matches the number of one of the family members listed as eligible to have his/her cost of services counted toward meeting the SOC. (A member of the Medi-Cal Family Budget Unit (MFBU).)

   c. The service dates for each line entry are within the month of eligibility shown.

   d. The service from and through dates of each listed service is on or before the date that the completed MC 177S was submitted to the county by the applicant.

   e. The provider Medi-Cal number or license number (if not a Medi-Cal provider), provider name, and provider signature is present for each service listed. (Stamped provider signatures are not acceptable unless initialed by the provider.)

f. A procedure number or drug code is entered for each service listed.

g. The specific medical service rendered is identified in the "Service Description".

h. The total of the "Billed Patient" amounts equals the SOC entered at the top of the MC 177S.

i. The beneficiary or person acting on behalf of the beneficiary has signed the MC 177S.

3. Date of Certification

A certification date is required to ensure that all claims for services provided on or before the certification date are reviewed by the fiscal intermediaries to prevent payment by Medi-Cal of those services actually used to meet the SOC.

The certification date is the most recent date of service shown on the completed MC 177S and must be entered in the "State Use Only" field on the MC 177S. The reviewer must sign beneath the certification date entry. Example: A beneficiary received services on the 5th, 10th, and 12th of the month; he/she paid or obligated for the services, which satisfied the SOC. The MC 177S is submitted to the county on the 15th. The certification date is the 12th of the month.

If any of the services listed on the MC 177S were not required to meet the client's SOC, the county should follow the procedures specified in Title 22, Section 50658 (b) (3).

If the most recent service was not required to meet the client's SOC, but agreement between the provider, county, and beneficiary cannot be reached to remove that service from the MC 177S, the date of that service must be used as the certification date.

4. Medi-Cal Card Issuance

Immediate need SOC Medi-Cal cards should always be issued via MEDS unless that system cannot be used for some reason. The MEDS Manual provides specific instructions for county SOC card issuance.

Each Medi-Cal card issued by the county to a certified SOC eligible must contain a certification date.

Immediate need Medi-Cal cards may only be issued to eligibles who have certified a medical need for them on the MC 110. Upon receipt of the signed MC 110 and certification that the SOC has been met, the county department shall issue current month Medi-Cal cards with MEDI and proof of eligibility (POE) labels to persons indicated on the MC 110. However, the county department shall not issue cards to all members of the MFBU unless it has been certified on the MC 110 that all members of the MFBU require cards in order to receive needed services prior to the receipt of a DHS-issued card.

PAST MONTHS CARDS SHALL NOT BE ISSUED BY THE COUNTY DEPARTMENT, except under the following conditions: (a) it has been at least ten months since the month of eligibility in question and a card is needed so that a provider can submit a Medi-Cal claim within one year of the date of service, or (b) the provider refuses to see the beneficiary until a POE label for a past month's service is made available. In both situations a card shall be issued only if the beneficiary has met the SOC for the month in question.

The notation "C.I." (card issued) must be placed to the left of the person's identification line on the MC 177S for eligibles who are issued immediate need SOC Medi-Cal cards. This alerts Key Data Entry Unit that a county-issued card has been produced and prevents central issuance of another card to the beneficiary.

5. Temporary Medi-Cal ID Card (MC 301) Issuance and Reporting

The MC 301 is used when MEDS is not available for card issuance for SOC eligibles who have certified an immediate need for a Medi-Cal card. When issuing an MC 301 card, the following procedures must be used in addition to those previously outlined. (The MC 301 format is given in Article 14A.)

The MC 301 card must be typed without errors or corrections of any kind. Cards or labels with errors must be voided. If a county-certified SOC eligible requests an additional MC 301 card because he/she has exhausted all labels on the card, but still has the body of the card, MEDS should be checked. If the beneficiary's record has been updated on MEDS, the county may issue additional POE labels via MEDS. Otherwise an additional MC 301 card containing only POE labels may be issued. In addition, the beneficiary should be informed that providers may photocopy the ID portion of the Medi-Cal card as proof of eligibility.

The county must inform DHS of the issuance of MC 301 Medi-Cal cards for certified eligibles. The report may be submitted on a "Control Log for MC 301" (form HAS 2007) or via MEDS. (See MEDS Manual for procedures on county card issuance log reporting.)

6. Submission of Form MC 177S to the State

MC 177S forms for persons certified by the county must be forwarded to the Key Data Entry Unit within seven working days from issuance of a card.

This is to permit:

a. MEDS issuance of Medi-Cal cards for those family members who did not have cards issued to them by the county.

b. Confirmation by MEDS of immediate need issued Medi-Cal cards.

c. Issuance of replacement supplemental cards via MEDS for county-certified eligibles.

d. Processing of provider Medi-Cal claims for eligibles with an SOC in order to prevent Medi-Cal payment of services which were paid or obligated toward the SOC.

MC 177S forms are to be mailed to:

Department of Health Services
Att: Data Systems Branch
Key Data Entry
P. O. Box 160400
Sacramento, CA 95816-0400

7. Delayed Requests for MC 301 Cards

If the county has forwarded the MC 177S to Key Data Entry Unit for certification of a case, and the client then requests an immediate need Medi-Cal card before the centrally issued cards have been received, the county should:

a. Query the MEDS Full Status Inquiry screen to determine whether the case has been certified.

b. If MEDS shows the case has not been certified, the county should obtain the client need statement, and perform the county certification and card issuance process via MEDS unless that system is unavailable. If an MC 301 must be issued, the county must log the temporary card issuance on MEDS on line to prevent state issuance of a Medi-Cal card or submit an HAS 2007.

c. If, because of timing, it appears that the client will receive both a county-issued and a state-issued card, instruct the client to return state-issued cards to the county.

8. Resubmission of MC 177S Forms

If the county receives a MEDS renewal alert requesting confirmation of a county-issued card, or the beneficiary has not received a Medi-Cal card after a reasonable period of time and county records show the MC 177S was sent, the county must resubmit the MC 177S.

With the implementation of the automated SOC claims processing system used by the fiscal intermediary, Computer Sciences Corporation (CSC), use of an original MC 177S form is required. The original MC 177S form is encoded by CSC for electronic scanning; therefore, a photocopy/ carbon copy cannot be processed through their system.

The following procedures must be followed when original MC 177S forms are not received by DHS.

a. Transfer all of the information that was on the first MC 177S form, except for signatures of the beneficiary and provider(s), onto a new original MC 177S form.

b. Attach the copy of the first MC 177S form submitted showing beneficiary and provider signatures. This may be a carbon copy or a photocopy as long as the signatures are legible.

c. Attach a note of explanation when resubmitting original forms with attached copies showing signatures. The note should have the following statement: "MC 177S resubmission, copy of MC 177S attached showing signatures." This note will alert Key Data Entry that the "signatures" are included as an attachment to the original.

12 C – PROCESSING CASES WHEN A SHARE OF COST HAS BEEN REDUCED RETROACTIVELY

A. Background

California Code of Regulations, Title 22, Section 50653.3(c), discuss the need to make adjustments when a person has been determined to have a lower Medi-Cal SOC for a given month(s) than was originally computed. Welfare and Institutions Code Paragraph 14019.3 speaks to provider return of payments for services covered by Medi-Cal. Persons determined to be entitled to a lower share of cost (SOC) have the option of:

1. Having future SOC amounts adjusted by the county; or

2. Adjusting with providers, the amounts obligated or paid to those providers to meet the overstated portion of the original SOC.

If an individual is seeking an adjustment of a future SOC and transfers to another county prior to receiving the full adjustment, the former county of responsibility must inform the new county of the adjustment amount that is still due.

Beneficiaries whose future SOC is zero before an adjustment is applied, must be advised that the only recourse is to seek reimbursement from the provider. In any situation where a beneficiary chooses to seek reimbursement from a provider, it must first be determined whether the provider has billed or submitted a SOC clearance transaction for the month which reimbursement is requested. This may be determined by reviewing the Medi-Cal Eligibility Data System (MEDS), SOC Case Make-Up inquiry Request (SOCR) screen for the appropriate month. If the SOC shown on SOCR for the appropriate month is the same as the county's computed SOC, then a provider has not submitted a SOC clearance transaction. If the remaining SOC is less than the SOC or zero, then a Medi-Cal provider has submitted one or more SOC clearance transactions. The SOC for back months cannot be reduced on MEDS to an amount lower than the amount of clearance transactions posted. For example, if the SOC is $100 and a provider has submitted a $25 SOC clearance transaction for medical services rendered, the SOC cannot be reduced to an amount lower than $25. Therefore, if the SOC is being reduced to $40 (any amount below $100), this new SOC amount would be input to MEDS and no SOC adjustment is necessary. When the SOCR screen shows none of the SOC being met, the lower SOC can be input into the MEDS system and no SOC adjustment is necessary.

SOCR information only goes back 12 months. If the month of overcharge is for an over 12 months from date of processing and not on SOCR, call the Medi-Cal Eligibility Branch Confidentiality/MEDS Analyst at (916) 657-1401 or send an e-mail to aramirez@dhs.ca.gov.

Prior to seeking reimbursement from the provider, beneficiaries shall be instructed by the county to give the provider a "Share of Cost Medi-Cal Provider Letter" (MC 1054 -- See Attachment I) so that the provider may bill the Medi-Cal program and reimburse the client the appropriate SOC amount. The "Share of Cost Medi-Cal Provider Letter" explains the reimbursement and billing procedures and the recomputation of the SOC.

B. Case Situations

The following procedures describe the adjustment process and the different methods for working with various case situations in recomputing the SOC.

Adjustment of SOC Amount

Case Situation 1: Beneficiary was determined eligible for July with a SOC and met the SOC (determined by viewing SOCR screen). It is later determined that the SOC should have been lower. Beneficiary requests adjustment of future SOC amounts.

Case Processing Steps

a. The county shall recompute the SOC for the overstated SOC month(s). Prepare a new MC 176 M for the month of July. The difference between the original and recomputed SOC is the amount of the adjustment.

b. On the MC 176M for September (the future months in which the SOC is to be adjusted), enter the SOC adjustment for the month of July on line 15. Subtract line 15 from line 14 and enter in line 16. Line 16 is the SOC for September which reflects the July overcharge. If the amount of the adjustment is greater than the September SOC amount, the beneficiary is not required to meet a SOC for that month. If necessary, repeat this process for subsequent months until the entire adjustment is made.

Case Situation 2: Beneficiary was determined eligible for October 1999 with a SOC and met part of the SOC for this month. It is later determined that the SOC should have been lower. Beneficiary requests adjustment of the future SOC.

a. View SOCR screen for month to determine amount of SOC that was met.

b. If it is determined that a provider submitted SOC clearances for more than the beneficiary's recomputed SOC, a SOC adjustment is needed. The difference between the amount cleared and the recomputed SOC will be the amount to be adjusted (e.g., client's original SOC is $100, beneficiary paid $75; the recomputed SOC is $50, the amount to be adjusted for future month is $25).

c. Process case according to steps listed for items a-b in Case Situation 1.

d. If the amount cleared for the month of October is less than the recomputed SOC, no adjustment is necessary. The change in the SOC needs to be posted to MEDS, if being processed within a year from the month of the overstated SOC.

Provider Reimbursement of SOC

Case Situation 3: Beneficiary was determined eligible for November 1999 with a SOC and met the SOC. A recomputation indicates the SOC should have been zero. Beneficiary wants a reimbursement of the SOC amount paid to the provider(s).

a. The county shall recompute the SOC for the overstated SOC month(s). Prepare a new MC 176 M for the month of November.

b. The county shall also prepare an MC 1054 explaining the SOC Adjustment and give or mail it to the beneficiary.

c. The client gives the MC 1054 to the provider (s).

d. The provider(s) bills Medi-Cal and reimburses the beneficiary after payment from Medi-Cal is received. The provider needs to submit a copy of the MC 1054 with their Medi-Cal billing.

Case Situation 4: Beneficiary was determined eligible for September with a SOC and met the SOC. A recomputation indicates the SOC should have been lower. Beneficiary wants reimbursement for the excess SOC amount paid. The provider(s) billed Medi-Cal for a portion of the SOC.

a. The county shall recompute the SOC for the overstated SOC month(s). Prepare a new MC 176 M for the month of September.

b. The county prepares an MC 1054 for the beneficiary.

c. The client submits the MC 1054 to the provider(s).

d. The provider(s) bills Medi-Cal and reimburses the beneficiary after payment from Medi-Cal is received. The provider needs to submit a copy of the MC 1054 with their Medi-Cal billing.

Case Situation 5: Beneficiary had a SOC for the previous month of April of $100, and according to the MEDS SOCR screen, met $50 of this SOC. It was later determined that the SOC should have been $75.

a. In this situation there is no SOC adjustment.

b. The MEDS SOC for April needs to be changed to $75 if processed within one year from the overstated SOC month.

Case Situation 6: Beneficiary had a SOC for the previous month of May in the amount of $200. The SOCR screen indicates that $150 of the SOC was met. It has been determined that the SOC should be $100.

a. Change the SOC on MEDS to $150 (MEDS will not accept a change below the amount of services that has already been credited towards the SOC).

b. County prepares an MC 1054 showing the original SOC as $150 and the revised amount as $100 and gives or sends it to the beneficiary.

c. The beneficiary submits the MC 1054 to the provider(s).

d. The provider(s) bills Medi-Cal and reimburses the beneficiary after payment from Medi-Cal is received. The provider needs to submit a copy of the MC 1054 with their Medi-Cal billing.

Case Situation 7: Beneficiary had a SOC for a month, that over a year ago was in the amount of $200, and it has been determined that the SOC should have been only $100.

a. To determine whether or not any of the SOC was met, contact the Medi-Cal Eligibility Branch MEDS Confidential Analyst at (916) 657-1401 or e-mail at aramirez@dhs.ca.gov/, if beneficiary met any or all or the SOC. If none of the SOC was met, no further action is needed. If all or an amount over the new SOC was met, proceed to the next steps.

b. If MEB determined that the provider(s) submitted SOC clearance transmittals in the amount or $175, a provider rebilling is needed. County prepares a "Letter of Authorization" (MC 180 – See Attachment II) and a MC 1054 which shows the original SOC as $200, and the revised SOC as

$100. If only $100 or less of the SOC had been met, there would not be a need to complete the MC 1054 or the MC 180, as the beneficiary would not be entitled to a refund from the provider(s).

c. The provider(s) bills Medi-Cal and reimburses the beneficiary after payment from Medi-Cal is received. The provider needs to submit a copy of the MC 180 and the MC 1054 with their Medi-Cal billing.

State of California—Health and Human Services Agency Department of Health Services

SHARE-OF-COST MEDI-CAL PROVIDER LETTER

(COUNTY STAMP)

Provider name and address

Notice date _____

Case name _____

Case number _____

EW name _____

EW number _____

EW address _____

_____

EW telephone number _____

_____ (Beneficiary's name), _____ (Beneficiary's Social Security number), was determined eligible for Medi-Cal with a share of cost that has been changed for the following months

Month/Year						
Original SOC						
Revised SOC						
Month/Year						
Original SOC						
Revised SOC						

The California Code of Regulations Title 22 Section 51471 1 requires providers to cooperate with the Department of Health Services in making reimbursements to the beneficiaries for Medi-Cal program underpayments The Welfare and Institutions Code, Section 14019 3 and the regulations further require that the provider accept an underpayment adjustment from the Medi-Cal program for such beneficiaries and reimburse such beneficiaries the full amount of that adjustment, up to the actual amount received in payment from the beneficiary for medical services in question

You must do one of the following if the beneficiary paid or obligated to pay an original share of cost (SOC) amount to you

If you	And the share of cost	Then you
billed Medi-Cal for the balance of the charges	has been reduced or is now zero	may bill the program for the difference between the original share of cost and the adjusted share of cost Submit a Claims Inquiry Form (CIF) with this MC 1054 attached ***Note: Do not submit a new claim It will be considered a duplicate claim and payment will be denied***
did not bill Medi-Cal because the charges equaled or were less than the original SOC	has been reduced	may bill the program if the services you rendered now exceed the adjusted SOC Submit a claim with the adjusted SOC amount in the Patient s Share of Cost" field and attach this MC 1054
	is now zero	may bill the program for the services you rendered Submit a claim with a zero (0) in the "Patient s Share of Cost" field and attach this MC 1054 form.

Once the CIF is approved and payment is received you are required to reimburse the beneficiary any share of cost paid for the services or eliminate/adjust the outstanding share of cost obligated for the services billed

MC 1054 (10/99)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY
DEPARTMENT OF HEALTH SERVICES

ELIGIBILITY LETTER OF AUTHORIZATION

Document Number 403406

Issuance Date of MC-180: ____ Date

** Provider Name: _____

** Provider No.: _____

Beneficiary's Name, Address, City, State and Zip

Issuing County:
SSN / Pseudo No.:
County I.D.:
Date of Approval (SSI only):
* Worker's Name:
* Worker's Number:
* Worker's Telephone #:
Other Health Coverage (Code):

MEDI-CAL BILLING FOR:

Mo. Yr.	Mo. Yr.	Mo. Yr.	Mo. Yr.
Mo. Yr.	Mo. Yr.	Mo. Yr.	Mo. Yr.
Mo. Yr.	Mo. Yr.	Mo. Yr.	Mo. Yr.

This original numbered MC-180 is approval for Medi-Cal providers to bill services provided to you during the above referenced months. An MC-180 is being issued in accordance with Title 22, California Code of Regulations (CCR) Section 50746. This regulation permits county welfare departments to issue documentation of eligibility which can be used by beneficiaries for periods more than one year after the month of service as a result of one of the following reasons:

1. ☐ SSI/SSP eligibility was approved for a retroactive period but cards were not issued by the State Department of Health Services.
2. ☐ A court order requires that Medi-Cal be issued.
3. ☐ A State Hearing or other administrative hearing decision requires that Medi-Cal be provided.
4. ☐ The State Department of Health Services requests that Medi-Cal be issued. (Original signature of an authorized DHS staff person: _____).
5. ☐ An Administrative Error has occurred. (Description) _____

Please immediately give your doctor or other medical provider this form for the applicable month(s)/year(s) of service. Providers do not need to submit a Medi-Cal proof of eligibility label with their claims when using this MC-180.

If you were provided services by more than one doctor or provider, please contact your local welfare office immediately to obtain additional original form(s).

INSTRUCTIONS TO PROVIDER
Submit this form, along with the claim(s), to:

EDS Federal Corporation
Attention: Over-One-Year-Unit
P.O. Box 13029
Sacramento, CA 95813-4029

(Original Signature of Authorized County Administrative Staff)

* This information is not needed when eligibility is established by the Social Security Administration.
** Optional

12D — PROCESSING CASES WHEN AN INCREASE IN SHARE OF COST IS DETERMINED BECAUSE OF INCOME OR FAMILY COMPOSITION CHANGES

A. Background

The following procedures describe how cases should be processed when the county determines an increase in share of cost is necessary due to a change in income or family composition. These procedures must be followed to ensure proper Medi-Cal certification, Medi-Cal card issuance, and provider claims processing.

B. Increase in Share of Cost Due to Change in Income

Case Situations

Case Situation 1 — Medi-Cal Family Budget Unit (MFBU) was determined eligible for July, August, and September without a share of cost. On August 5, a member of the MFBU became employed. A recomputation indicates a share of cost should be established for the quarter. The county is able to send proper notice of action increasing the share of cost as of September 1 for the July through September period.

Case Processing Steps

1. The county shall compute the July through September share-of-cost amount and revise the MC 176M for the case file. The change in income is reflected for September only as a ten-day notice must be given.

2. The county shall prepare an MC 177S showing the share-of-cost period as September only. Since the client received cards for July and August, only September expenses are to be applied toward the share of cost.

3. The client should have his/her providers complete the MC 177S.

4. Upon completion of the MC 177S by the provider, the client must sign and return the form to the county.

5. The county will forward the MC 177S to the Department's Benefits Review Unit (BRU) for certification and Medi-Cal card issuance.

Case Situation 2 — MFBU is determined to have a share of cost for June, July, and August of $300. MFBU meets the $300 share of cost on June 5 and has been certified. On June 25, the county receives information that Mr. "Y" is now employed. The county is able to recompute the share of cost and send proper notification increasing the share of cost to $500 effective August 1.

Case Processing Steps

1. Recompute the share of cost for June, July, and August. The change in income is reflected for August only as a ten-day notice must be given.

2. Contact BRU as described in Article 12F.

3. Prepare a supplemental MC 177S for August only showing the share of cost as $200 (difference between old and new recomputed share of cost).

4. The client should have his/her providers complete the MC 177S.

5. Upon completion by the provider, the client must sign and return the form to the county.

6. The county will forward the MC 177S to the Department's BRU for certification of the remaining month in the period and issue a Medi-Cal card.

The above case processing will also apply if an increase is made in the second month of the share-of-cost period.

Case Situation 3 — MFBU is determined to have a share of cost for June, July, and August of $300. On June 25, the county receives information that Mr. "Y" is now employed. The MFBU has not met the original share of cost. The county is able to recompute the share of cost and send proper notification increasing the share of cost to $500 for the quarter.

Case Processing Steps

1. Recompute the share of cost for June, July, and August. The change in income is reflected for August only as a ten-day notice must be given.

2. Prepare a new MC 177S or revise the original (if available) showing the total recomputed share of cost of $500. If the original MC 177S has services listed on it and is to be attached to an additional MC 177S, then line out the share of cost on the original MC 177S and place the full amount on the new MC 177S.

3. The client should have his/her providers complete the MC 177S.

4. Upon completion by the provider, the client must sign and return the form to the county.

5. The county will forward the MC 177S to the Department's BRU for certification and card issuance.

C. Increase in Share of Cost Due to Change in Family Composition

Case Situations

Case Situation 1 — MFBU includes Mr. "X", Mrs. "X", and their three children. The multimonth share-of-cost period is July, August, and September. The MFBU has not met the share of cost. On July 22, Mrs. "X" calls to report that the oldest child has left the home as of July 15.

Case Processing Steps

1. The county shall exclude the child from the maintenance need as of September since a ten-day notice must be sent to notify the MFBU of an increase in the share of cost.

2. The county shall recompute the share of cost for the period reflecting the change for September. An additional MC 177S is to be issued for September showing the revised share of cost. The child's name should appear on the MC 177S with only eligibility months "A" and "B" checked. If the original MC 177S has services listed on it and the county opts to attach it to an additional MC 177S, then line out the share of cost amount on the original MC 177S and place the full amount on the new MC 177S.

3. Providers of service are to complete the MC 177S. Upon completion, the client must sign and return the MC 177S to the county.

4. The county shall verify the completeness of the MC 177S and forward it to BRU for certification and card issuance.

Case Situation 2 — Same situation as described in C1 above except that the MFBU has met the share of cost prior to the child leaving the home.

Case Processing Steps

1. Contact BRU as described in Article 12F to remove the child from the case for September and to hold the MFBU September Medi-Cal cards until the supplemental share of cost is met.

2. The county shall exclude the child from the maintenance need as of September since a ten-day notice must be sent to notify the MFBU of an increase in the share of cost.

3. The county shall recompute the share of cost for the period. The child's name is not to appear on the supplemental MC 177S.

4. Providers of service are to complete the supplemental MC 177S. Upon completion, the client must sign and return the MC 177S to the county.

5. The county shall verify the completeness of the MC 177S and forward it to BRU for certification and card issuance.

Case Situation 3 — Examples 1, 2, and 3 show the MC 176M and MC 177S when a share of cost is to be increased because an excluded family member, who has earnings, is being added to the MFBU. The MFBU has a $90 multimonth share of cost which increases by $10 each month that the previously excluded person is in the MFBU. The increase is immediately computed since a ten-day notice is not required when an excluded person is added to the MFBU (Section 50015). In all examples, the MFBU has met the share of cost and received Medi-Cal cards prior to the inclusion of the excluded person.

Example 1 shows the MC 176M and MC 177S when the son is excluded from the MFBU.

Example 2 shows the MC 176M and MC 177S when the MFBU has met the share of cost and received Medi-Cal cards for April and May. The son is then included in the MFBU for May and June.

1. The county shall contact BRU to include the family member in the MFBU and to stop the issuance of June Medi-Cal cards to the MFBU in accordance with instructions described in Article 12F.

2. The county shall recompute the share of cost to include the son's earnings for May and June and increase the maintenance need accordingly. The effective eligibility date of the budget must be shown as May and June.

3. The county shall prepare a supplemental MC 177S showing May and June as the months for which medical expenses may be listed. Only the son is to be listed as eligible for May on the MC 177S since the rest of the MFBU has met the share of cost and received Medi-Cal cards. Everyone is listed as eligible for June since Medi-Cal cards have not yet been issued for June.

4. Upon completion by the provider, the client must sign and return the MC 177S to the county. The county shall forward the MC 177S to BRU for certification and card issuance.

Example 3 shows the MC 176M and MC 177S when the MFBU has met the share of cost and received Medi-Cal cards for April, May, and June and also for the prior multimonth share of cost period of January, February, and March. The son is to be included in the MFBU for June and also to receive retroactive eligibility for March, April, and May.

1. The county shall recompute the April, May, and June share of cost to include the son's earnings for all three months and increase the maintenance need for all three months.

2. The county shall separately recompute the MFBU's January, February, and March share of cost to include the son's earnings for March only and increase the maintenance need in March only. The son is still an excluded person for January and February; therefore, his income for those months is not to be used when recomputing the share of cost for that multimonth period. The effective eligibility date of the budget must be shown as March only.

3. The county shall prepare a supplemental MC 177S showing April, May, and June as the months for which medical expenses may be listed. Only the son is to be listed as eligible for April, May, and June since the rest of the MFBU has met the share of cost and received Medi-Cal cards.

4. The county shall separately prepare a supplemental MC 177S showing March as the month for which medical expenses may be listed. Only the son is to be listed as eligible for March since the rest of the MFBU has met the share of cost and received Medi-Cal cards.

5. Upon completion by the provider, the client must sign and return the MC 177S to the county. The county shall forward the MC 177S to BRU for certification and card issuance.

1. The county shall recompute the April, May, and June share of cost to include the son's earnings for all three months and increase the maintenance need for all three months.

2. The county shall separately recompute the MFBU's January, February, and March share of cost to include the son's earnings for March only and increase the maintenance need in March only. The son is still an excluded person for January and February; therefore, his income for those months is not to be used when recomputing the share of cost for that multimonth period. The effective eligibility date of the budget must be shown as March only.

3. The county shall prepare a supplemental MC 177S showing April, May, and June as the months for which medical expenses may be listed. Only the son is to be listed as eligible for April, May, and June since the rest of the MFBU has met the share of cost and received Medi-Cal cards.

4. The county shall separately prepare a supplemental MC 177S showing March as the month for which medical expenses may be listed. Only the son is to be listed as eligible for March since the rest of the MFBU has met the share of cost and received Medi-Cal cards.

5. Upon completion by the provider, the client must sign and return the MC 177S to the county. The county shall forward the MC 177S to BRU for certification and card issuance.

SHARE OF COST DETERMINATION – MFBUs WHICH DO NOT INCLUDE LTC PERSONS

Case Name: EXAMPLE 1 | County District | County Use

☐ New Application ☐ Redetermination ☐ Change ☐ Retroactive Elig. ☐ Correction | Effective Eligibility Date for this Budget: Mo. Apr - May - Jun Yr. 82

State Number Co.	Aid	7 Digit Serial No.	MFBU	Pers. No	Name – First, Middle, Last	Birthdate Mo. Day Yr.	Sex	(1) Soc. Sec. No. and (2) Health Insurance Claim No. or Railroad Retirement No.	Other Coverage
49	85	0123456	0	01	Larry Larrence	9 14 38	m	(1) 512-34-5678	Y
49	85	0123456	0	02	Mary Larrence	6 20 39	F	(1) 512-98-7654	Y
49	83	0123456	0	10	Janet Larrence	5 14 69	F	(1) 522-34-5678	Y
	Excluded				John Larrence	7 7 63	m	(1) 521-98-7654	Y
								(1)	
								(2)	
								(1)	
								(2)	
								(1)	
								(2)	

L. Income of MFBU members applying as ABD plus income of spouse or parent (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1 a. ABD-MIN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MIN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MIN	Month 3 b. Spouse or Parent
1. Social Security						
2. Net Income from Property						
3. Other—Itemize						
4.						
5. Total (add 1 thru 4)						
6. Deductions						
7. Remainder (5 minus 6)	a.	b.	a.	b.	a.	b.
8. Combined unearned income (add 7a and 7b)						
9. Any income exclusion	–$20		–$20		–$20	
10. Countable unearned income (8 minus 9)						

B. NONEXEMPT EARNED INCOME

	Month 1 a. ABD-MIN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MIN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MIN	Month 3 b. Spouse or Parent
11. Gross Earned Income						
12. Deductions						
13. Remainder (11 minus 12)	a.	b.	a.	b.	a.	b.
14. Combined earned income (add 13a & 13b)						
15. SES earned inc. exclusion plus $ unused $20						
16. Remainder (14 minus 15)						
17. Countable earned income (divide 16 by 2)						

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month 3
18. Total countable income (add 10 and 17)			

1L. Income of MFBU members not listed in L (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1	Month 2	Month 3
1. Social Security			
2. Net income from property			
3. Other—Itemize			
4.			
5. Total unearned income (add 1 thru 4)			
6. Deductions			
7. Countable unearned income (5 minus 6)	$ →		

B. NONEXEMPT EARNED INCOME

	Month 1	Month 2	Month 3
8. Gross earned income	900 →		
8a. If CG in Net 4 mos. enter $30			
8b. 1/3 remainder			
10. mandatory	200		
11. Work Related	75		
12. Total deduct. (add 9, 10, & 11)	275		
13. Countable earned income	625 →		

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month 3
14. Subtotal (add 7 and 13)	625 →		
15. Child support/ alimony			
16. Total countable income (14 minus 15)	625 →		

MC 176m (9/81)

III. SHARE OF COST COMPUTATION – NON LTC

Case Name:

	Month 1	Month 2	Month 3
1. Countable income from I 18			
2. Countable income from II 16	625.	→	→
3. Inc. allocated from LTC/B&C person to family members at home (176W Part IV)			
4. Combined countable income (add 1, 2, and 3)	625	→	→
ALLOCATIONS AND DEDUCTIONS			
5. Allocation to excluded children (176W, Part I)	0		
6. Special deduction (176W, Part II)	0		
7. Income to determine PA Eligibility	0		
8. Health insurance	12.50	→	→
9.			
10.			
11. Total allocations/deductions (add 5 through 10)	12.50	→	→
12. Total net nonexempt income (4 minus 11)	612.50	→	→
13. Total net nonexempt income rounded	613	613	613
14. Maintenance need	583	583	583

SHARE OF COST

13a. Total of Mos. 1, 2, and 3	1839
14a. Total of Mos. 1, 2, and 3	1749
15. Share of cost (13a. minus 14a.)	90
16. Underpayment adjustment	
17. Adjusted Share of Cost (15 minus 16)	

IV. EXEMPT INCOME

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

Eligibility Worker Signature	Worker Number	Computation Date	County Use

EXAMPLE 1

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health Services

CO DIST | COUNTY: Sonoma

RECORD OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

Only medical expenses in the following months may be listed below.

Month A	Month B	Month C	Share of Cost: The amount that you must pay or obligate for	Page	Retro. I
Apr 82	May 82	Jun 82	$ 90.00		No
Mo. Yr.	Mo. Yr.	Mo. Yr.			(Yes/N

Name

Address

City/State/Zip

County Code: 49

Medical expenses of family members listed below may be used to meet Share of Cost

State Number: Aid	7 Digit Serial No.	PEU	Rem.	Name — Last, First	Eligible for: A	B	C	Birthdate: Mo.	Day	Yr.	Sex	Other Cov. Code	Social Security No.	HIC or RR No.
85	0123456	1	01	Lawrence, Larry	X	X	X	9	14	38	M	Y	512 34 5678	
85	0123456	1	02	Lawrence, Mary	X	X	X	6	20	39	F	Y	512 98 7654	
83	0123456	1	10	Lawrence, Janet	X	X	X	5	14	69	F	Y	522 34 5678	
	Excluded			Lawrence, John				7	7	63	M	Y	521 98 7654	

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I ha payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal progra this amount. I also understand and agree that I may seek payment from the Medi-Cal program for the cost of my service in excess of the amount billed to the pa This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I am insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME / Provider No.	Date of Service: Mo. Day Yr.	SERVICE	Proc. Code/ Proc. No.	Total Bill $	Billed Patient $	Billed Medi-Cal $
PATIENT NAME						
PROVIDER SIGNATURE (See Declaration Above)						
PROVIDER NAME / Provider No.						
PATIENT NAME						
PROVIDER SIGNATURE (See Declaration Above)						
PROVIDER NAME / Provider No.						
PATIENT NAME						
PROVIDER SIGNATURE (See Declaration Above)						
PROVIDER NAME / Provider No.						
PATIENT NAME						
PROVIDER SIGNATURE (See Declaration Above)						

STATE USE ONLY

Mo. Day Yr. Date of Certification | Reviewed By: | Trans. | Reason

I have read the instructions on the back of this form. I agree to assume full legal responsibility for th amounts listed above in the "Billed Patient" column.

X SIGNATURE OF APPLICANT DATE

SHARE OF COST DETERMINATION – MFBUs WHICH DO NOT INCLUDE LTC PERSONS

Case Name: EXAMPLE 2 | County District: | County Use:

☐ New Application ☐ Redetermination ☒ Change ☐ Retroactive Elig. ☐ Correction

Effective Eligibility Date for this Budget: Mo. May–Jun Yr. 82

State Number: Co.	Suf.	Client Serial No.	MFBU No.	Pers. No.	Name – First, Middle, Last	Birthdate Mo. Day Yr.	Sex	(1) Social Security No. and (2) Health Insurance Claim No. or Railroad Retirement No.	Other Coverage
								(1) (2)	
								(1) (2)	
								(1) (2)	
49	83	012345	6	01	John Lawrence	7 7 63	M	(1) 321-45-7654 (2)	Y
								(1) (2)	
								(1) (2)	
								(1) (2)	

I. Income of MFBU members applying as ASD plus income of spouse or parent (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1 a. ABD-MN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MN	Month 3 b. Spouse or Parent
1. Social Security						
2. Net income from property						
3. Other—Itemize						
4.						
5. Total (add 1 thru 4)						
6. Deductions						
7. Remainder (5 minus 6)	a.	b.	a.	b.	a.	b.
8. Combined unearned income (add 7a and 7b)						
9. Any income exclusion	–$20		–$20		–$20	
10. Countable unearned income (8 minus 9)						

B. NONEXEMPT EARNED INCOME

	Month 1 a. ABD-MN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MN	Month 3 b. Spouse or Parent
11. Gross Earned Income						
12. Deductions						
13. Remainder (11 minus 12)	a.	b.	a.	b.	a.	b.
14. Combined earned income (add 13a & 13b)						
15. $65 earned inc. exclusion plus $ unused $20						
16. Remainder (14 minus 15)						
17. Countable earned income (divide 16 by 2)						

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month 3
18. Total countable income (add 10 and 17)			

II. Income of MFBU members not listed in I. (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1	Month 2	Month 3
1. Social Security			
2. Net income from property			
3. Other—Itemize			
4.			
5. Total unearned income (add 1 thru 4)			
6. Deductions			
7. Countable unearned income (5 minus 6)		0	→

B. NONEXEMPT EARNED INCOME

	Month 1	Month 2	Month 3
8. Gross earned income		1100	→
9a. If 65 in last 4 mos. enter $20			
9b. 1/3 remainder			
10. Mandatory		250	→
11. Work Related		106	→
12. Total deduc. (add 9, 10, & 11)		356	→
13. Countable earned income		744	→

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month 3
14. Subtotal (add 7 and 13)		744	→
15. Child support/ alimony			
16. Total countable income (14 minus 15)		744	→

III. SHARE OF COST COMPUTATION – NON LTC

Case Name:

	Month 1	Month 2	Month 3
1. Countable income from I 18			
2. Countable income from II 18		744	→
3. Inc. allocated from LTC/S&C person to family member at home (175W, Part IV)			
4. Combined countable income (add 1, 2, and 3)		744	→
ALLOCATIONS AND DEDUCTIONS			
5. Allocation to excluded children (176W, Part I)			
6. Spouse deduction (176W, Part II)			
7. Income to determine PA Eligibility			
8. Health insurance		12.50	→
9.		~~12.50~~	→
10.			
11. Total allocations/deductions (add 5 through 10)		12.50	→
12. Total net nonexempt income (4 minus 11)		731.50	→
13. Total net nonexempt income rounded	613	732	732
14. Maintenance need	583	692	692

SHARE OF COST

13a. Total of Mos 1, 2, and 3	2077
14a. Total of Mos. 1, 2, and 3	1967
15. Share of cost (13a. minus 14a.)	110
16. Underpayment adjustment	
17. Adjusted Share of Cost (15 minus 16)	

IV. EXEMPT INCOME

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

5/12/82 mother requested that son John be included in the MPBU for May and ongoing. John was previously excluded

Eligibility Worker Signature	Worker Number	Computation Date	County Use

State of California—Health and Welfare Agency
Medi-Cal Program

EXAMPLE 2

Department of Health Ser

CO DIST	COUNTY U
	Sonoma

RECORD OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

Only Medical expenses in the following months may be listed below.			Share of Cost	Page
Month A	Month B	Month C	The amount YOU must pay or obligate as:	Applic. I
Mo. Yr.	May 82 Mo. yr.	Jun 82 Mo. Yr.	$ 200.00	No (Yes/No)

Name

Address

City/State/Zip

County Code
49

Medical expenses of family members listed below may be used to meet Share of Cost

State Number: Aid	7 Digit Serial No.	FSU	Aux.	Name — Last, First	Eligible in: A	B	C	Birthdate: Mo.	Day	Yr.	Sex	Other Ins. Code	Social Security No.	HIC or RR No.
85	0123456	0	101	Lawrence, Larry			X	9	14	38	M	Y	512 34 5678	
85	0123456	0	102	Lawrence, Mary			X	6	20	39	F	Y	512 98 7654	
83	0123456	0	10	Lawrence, Janet			X	5	14	69	F	Y	522 34 5678	
83	0123456	0	11	Lawrence, John		X	X	7	7	63	M	Y	521 98 7654	

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I ha payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal progra that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my services in excess of the amount billed to the pa This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME	Provider No.	Date of Service: Mo.	Day	Yr.	SERVICE	Proc. Code/ Proc. No.	Total Bill $	Billed Patient $	Billed Medi-Cal $
PATIENT NAME									
PROVIDER SIGNATURE (See "Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									

STATE USE ONLY

Mo. | Day | Yr. — Date of Certification

Reviewed By: — Form — Reviewed

I have read the instructions on the back of this form. I agree to assume full legal responsibility for th amounts listed above in the "Billed Patient" columns.

X SIGNATURE OF APPLICANT — DATE

SHAPE OF COST DETERMINATION – MFBUs WHICH DO NOT INCLUDE LTC PERSONS

Case name: EXAMPLE 3 | County District: | County Use:

☐ New Application ☐ Redetermination ☒ Change ☒ Retroactive Elig. ☐ Correction | Effective 6 mos. beg. Date for this Budget: Mo. Apr - May - Jun Yr. 82

State Number Co.	Aid	7 Digit Serial No.	MFBU No.	Pers. No.	Name – First, Middle, Last	Birthdate Mo. Day Yr.	Sex	(1) Social Security No. and (2) Health Insurance Claim No. or Railroad Retirement No.	Other Coverage
49	83	0123456	0	111	John Lawrence	7 7 53	M	(1) 521-93-7654 (2)	Y

I. Income of MFBU members applying as AED plus income of spouse or parent (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1 a. AED-MN	Month 1 b. Spouse or Parent	Month 2 a. AED-MN	Month 2 b. Spouse or Parent	Month 3 a. AED-MN	Month 3 b. Spouse or Parent
1. Social Security						
2. Net Income from Property						
3. Other—Itemize						
4.						
5. Total (add 1 thru 4)						
6. Deductions						
7. Remainder (5 minus 6)	a.	b.	a.	b.	a.	b.
8. Combined unearned income (add 7a and 7b)						
9. Any income deduction	-$20		-$20		-$20	
10. Countable unearned income (8 minus 9)						

B. NONEXEMPT EARNED INCOME

	Month 1 a. AED-MN	Month 1 b. Spouse or Parent	Month 2 a. AED-MN	Month 2 b. Spouse or Parent	Month 3 a. AED-MN	Month 3 b. Spouse or Parent
11. Gross Earned Income						
12. Deductions						
13. Remainder (11 minus 12)	a.	b.	a.	b.	a.	b.
14. Combined earned income (add 13a & 13b)						
15. $65 earned inc. deduction plus $ unused $20						
16. Remainder (14 minus 15)						
17. Countable earned income (divide 16 by 2)						

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month 3
18. Total countable income (add 10 and 17)			

II. Income of MFBU members not listed in I (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1	Month 2	Month 3
1. Social Security			
2. Net Income from property			
3. Other—Itemize			
4.			
5. Total unearned income (add 1 thru 4)			
6. Deductions			
7. Countable unearned income (5 minus 6)			

B. NONEXEMPT EARNED INCOME

	Month 1	Month 2	Month 3
8. Gross earned income	1100	→	→
9a. If CG or last 4 mos. over $20			
9b. 1/3 remainder			
10. Mandatory	250		
11. Work Rel	106		
12. Total deduct. (add 9, 10, & 11)	356	→	→
13. Countable earned income	744	→	→

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month 3
14. Subtotal (add 7 and 13)	744	→	→
15. Child support/ alimony			
16. Total countable income (14 minus 15)	744	→	→

MC 176M (9/81)

III. SHARE OF COST COMPUTATION – NON LTC

Case Name:

	Month 1	Month 2	Month 3
1. Countable income from I 12	X		
2. Countable income from II 18	744	→	→
3. Inc. allocated from LTC/P&C person to family members at home (176W, Part IV)			
4. Combined countable income (add 1, 2, and 3)	744	→	→
ALLOCATIONS AND DEDUCTIONS			
5. Allocation to excluded children (175W, Part I)			
6. Special allocation (176W, Part II)			
7. Income to determine PA Eligibility			
8. Health insurance	12.50	→	→
9.			
10.			
11. Total allocations/deductions (add 5 through 10)	12.50	→	→
12. Total net nonexempt income (4 minus 11)	731.50	→	→
13. Total net nonexempt income rounded	732	732	732
14. Maintenance need	692	692	692

SHARE OF COST

13a. Total of Mos. 1, 2, and 3	2196
14a. Total of Mos. 1, 2, and 3	2076
15. Share of cost (13a. minus 14a.)	120
16. Underpayment adjustment	
17. Adjusted Share of Cost (15 minus 16)	

IV. EXEMPT INCOME

V. EXPLANATION OF CHANGES WITHIN SCC PERIOD

C/ 14/82 P/c Mrs. Larrence requested medi-Cal for John and retro eligibility back to march 82. John was previously excluded for ~~ex~~ income.

Eligibility Worker Signature	Worker Number	Computation Date	County Use

EXAMPLE 3

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health Services

CO DIST	COUNTY
	Sonoma

RECORD OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

Only medical expenses in the following months may be listed below.			Share of Cost	Paid
Month A	Month B	Month C	The amount that you must pay or agree to pay	Aged, Z
Apr 82	May 82	Jun 82	$ 30 00	Yes
Mo. Yr.	Mo. Yr.	Mo. Yr.		(Yes/No)

Name

Address

City/State/Zip

County Code
49

Medical expenses of family members listed below may be used to meet Share of Cost

State Number				Name — Last, First	Eligible in			Birthdate			Other Cov. Code	Social Security No.	HIC or RR No.
Aid	7 Digit Serial No.	FBU	Rem.		A	B	C	Mo.	Day	Yr.			
85	0123456	0	01	Larrence, Larry				9	14	38	M	Y	512 34 5678
85	0123456	0	02	Larrence, Mary				6	20	39	F	Y	512 98 7654
83	0123456	0	10	Larrence, Jane				5	14	69	F	Y	522 34 5678
83	0123456	0	11	Larrence, John	X	X	X	7	7	63	M	Y	521 98 7654

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I have received payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal program for that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the need of any service in excess of the amount listed to the right. This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot bill on this form the amount of the charge paid by the insurance or third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME	Provider No.	Date of Service Mo.	Day	Yr.	SERVICE	Proc. Code/ Proc. No.	Total Bill $	Billed Patient $	Billed Medi-Cal $
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									

STATE USE ONLY

Mo. | Day | Yr. | Approved By: | Total | Balance

Date of Certification

I have read the instructions on the back of this form. I agree to assume full legal responsibility for the amounts listed above in the "Billed Patient" column.

X
SIGNATURE OF APPLICANT DATE

SHARE OF COST DETERMINATION — MFBUs WHICH DO NOT INCLUDE LTC PERSONS

Case Name: EXAMPLE 3 | County District | County Use

☐ New Application ☐ Redetermination ☒ Change ☐ Retroactive Elig. ☐ Correction | Effective Eligibility Date for this Budget: Mo. March Yr. 82

State Number Co.	Aid	7 Digit Serial No.	MFBU	Pers. No.	Name – First, Middle, Last	Birthdate Mo.	Day	Yr.	Sex	(1) Social Security No. and (2) Health Insurance Claim No. or Railroad Retirement No.	Other Coverage
										(1) (2)	
										(1) (2)	
										(1) (2)	
49	83	0123456	0	11	John Lawrence	7	7	63	M	(1) 521-98-7654 (2)	Y
										(1) (2)	
										(1) (2)	
										(1) (2)	

I. Income of MFBU members applying for ABD plus income of spouse or parent (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1 a. ABD-MN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MN	Month 3 b. Spouse or Parent
1. Social Security						
2. Net income from property						
3. Other—itemize						
4.						
5. Total (add 1 thru 4)						
6. Deductions						
7. Remainder (5 minus 5)	a.	b.	a.	b.	a.	b.
8. Combined unearned income (add 7a and 7b)						
9. Any income exclusion	-$20		-$20		-$20	
10. Countable unearned income (8 minus 9)						

B. NONEXEMPT EARNED INCOME

	Month 1 a. ABD-MN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MN	Month 3 b. Spouse or Parent
11. Gross Earned Income						
12. Deductions						
13. Remainder (11 minus 12)	a.	b.		b.	a.	b.
14. Combined earned income (add 13a & 13b)						
15. $65 earned inc. deduction plus $ unused $20						
16. Remainder (14 minus 15)						
17. Countable earned income (divide 16 by 2)						

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month 3
18. Total countable income (add 10 and 17)			

II. Income of MFBU members not listed in I. (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1	Month 2	Month 3
1. Social Security			
2. Net income from property			
3. Other—itemize			
4.			
5. Total unearned income (add 1 thru 4)			
6. Deductions			
7. Countable unearned income (5 minus 6)			

B. NONEXEMPT EARNED INCOME

	Month 1	Month 2	Month 3
8. Gross earned income			1100
9a. If CG in last 4 mos. enter $20			
9b. 1/3 remainder			
10. Mandatory			250
11. Work Rel			108
12. Total deduct. (add 9, 10, & 11)			358
13. Countable earned income			742

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month 3
14. Subtotal (add 7 and 13)			742
15. Child support exempt			
16. Total countable income (14 minus 15)			742

III. SHARE OF COST COMPUTATION – NON LTC

Case Name:

	Month 1	Month 2	Month 3
1. Countable income from I 18			
2. Countable income from II 18			744
3. Inc. allocated from LTC 3&C person to family members at home (175W, Part IV)			
4. Combined countable income (add 1, 2, and 3)			744
ALLOCATIONS AND DEDUCTIONS			
5. Allocation to excluded children (175W, Part I)			
6. Spouse deduction (175W, Part II)			
7. Income to determine PA Eligibility			
8. Health insurance			12.50
9.			
10.			
11. Total allocations/deductions (add 5 through 10)			
12. Total net nonexempt income (4 minus 11)			731.50
13. Total net nonexempt income rounded	613	613	732
14. Maintenance need	583	583	692

SHARE OF COST

13a. Total of Mos. 1, 2, and 3	1958
14a. Total of Mos. 1, 2, and 3	1858
15. Share of cost (13a minus 14a)	100
16. Underpayment adjustment	
17. Adjusted Share of Cost (15 minus 16)	

IV. EXEMPT INCOME

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

See explanation on prior budget.

Eligibility Worker Signature	Worker Number	Computation Date	County Use

EXAMPLE 3

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health Svcs.

CC DIST. | COUNTY U
Sonoma

RECORD OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

Only medical expenses in the following months may be listed below.

Month A	Month B	Month C	Share of Cost: The amount that you must pay or obligate as	Page
Mo. Yr.	Mo. Yr.	Mar 82	$ 10.00	Retro. E: Yes

Name

Address

City/State/Zip

County Code: 49

Medical expenses of family members listed below may be used to meet Share of Cost

Aid	Social Security No. – 7 Digit Serial No.	PEU	Rel.	Name – Last, First	Eligible in A	B	C	Birthdate Mo.	Day	Yr.	Sex	Other Cov. Code	Social Security No.	MIC or BR No.
85	012345678	0	01	Larrence, Larry				9	14	38	M	N	512 34 5678	
85	012345678	0	02	Larrence, Marsy				6	20	39	F	N	512 98 7654	
83	012345678	0	10	Larrence, Janet				5	14	69	F	N	522 34 5678	
83	012345678	0	11	Larrence, John			X	7	7	63	M	N	521 98 7654	

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I am payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal program amount. I also understand and agree that I may seek payment from the Medi-Cal program for the cost of my services in excess of the amount stated to me in This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or third party.

I am aware that diagnostic information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME	Provider No.	Date of Service Mo.	Day	Yr.	SERVICE	Proc. Code/ Proc. No.	Total Bill $	Billed Patient $	Billed Medi-Cal $
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									

STATE USE ONLY

Mo. | Day | Yr. | Reviewed By: | Typed | Released

Date of Certification

I have read the instructions on the back of this form. I agree to assume full legal responsibility for th amounts listed above in the "Billed Patient" column.

X SIGNATURE OF APPLICANT DATE

12E — PROCESSING CASES WHEN A DECREASE IN SHARE OF COST IS DETERMINED BECAUSE OF INCOME OR FAMILY COMPOSITION CHANGES

A. Background

The following procedures describe how cases should be processed when the county determines a decrease in share of cost is necessary due to a change in income or family composition. These procedures must be followed to ensure proper Medi-Cal certification, Medi-Cal card issuance, and provider claims processing.

B. Decrease in Share of Cost Due to Change in Income

Case Situations

Case Situation 1 — Medi-Cal Family Budget Unit (MFBU) was determined eligible for July, August, and September with a share of cost of $500. On July 25, Mr. "X" lost his job. The MFBU had met the original share of cost and has been certified.

Case Processing

1. Recompute the share of cost reflecting the loss of any income for July and August provided Mr. "X" reported the loss of income within ten days.

2. Follow the appropriate procedures described in Article 12C after the MFBU has decided whether to have the future share of cost adjusted or reimbursement from providers.

   If the share of cost is reduced to zero, Benefits Review Unit (BRU) must be notified to cancel Medi-Cal card generation for the entire MFBU. (See Article 12F.) Counties will then request the remaining cards for the period via the Central Issuance Division (CID) or Medi-Cal Eligibility Data System (MEDS).

Case Situation 2 — Same example as Case Situation 1 above except MFBU has not met the share of cost.

Case Processing

1. Recompute the share of cost reflecting the loss of any income for July and August.

2. If the share of cost is reduced to a lower amount, issue a new MC 177S or revise the original MC 177S if available.

3. The client should submit the form MC 177S to the provider.

4. Upon completion of the MC 177S by the provider, the client must sign and return the form to the county.

5. The county will send form MC 177S to BRU for certification and card issuance.

C. Decrease in Share of Cost Due to Change in Family Composition

Case Situations

Case Situation 1 — MFBU was determined eligible for July, August, and September with a share of cost. On July 25, Mrs. "X" reports that Mr. "X" left the home. The change in family composition will lower the share of cost for the MFBU. The MFBU met the original share of cost.

Case Processing

1. Recompute the share of cost excluding Mr. "X" from the MFBU effective August 1.

2. Follow the appropriate procedures described in Article 12C after the MFBU has decided whether to have the future share of cost adjusted or reimbursement from providers.

3. Contact BRU as described in Article 12F. If the share of cost is reduced to zero, BRU must also be notified to cancel card generation for the entire MFBU. Counties will request the remaining cards for the period via the CID or MEDS. (See Article 12F.)

Case Situation 2 — Same example as Case Situation 1 except the MFBU has not met the share of cost.

Case Processing

Follow steps a-e in Case Situation B2 above.

12F — INCREASED SHARE OF COST (SOC) DUE TO VOLUNTARY INCLUSION OF ADDITIONAL FAMILY MEMBERS(S)

The purpose of this section is to provide instructions for processing cases in which there is an increased SOC due to the voluntary inclusion in the Medi-Cal Family Budget Unit (MFBU) of additional family member(s)

1. Background

Title 22, California Administrative Code, Section 50015, specifies that an increased SOC due to the voluntary inclusion in the MFBU of an eligible family member is not an adverse action; therefore, a ten-day advance notice is not required before increasing the SOC. If a financially responsible relative with income returns to the home and does not voluntarily request to be included in the MFBU, a ten-day advance notice is required before the SOC can be increased.

Example: Mrs. T and her two children are receiving Medi-Cal as an Aid to Families with Dependent Children-Medically Needy family due to absent parent deprivation. They do not have an SOC. Mr. T returns to the home on September 5. Based upon his income (DIB), the MFBU will have an SOC. Mr. T does not wish to be voluntarily included in the MFBU. A ten-day advance notice is required before Mr. T with his income is added to the MFBU. If Mr. T voluntarily requests Medi-Cal for September, a ten-day advance notice is not required, he and his income would be added to the MFBU effective September 1 and an adequate Notice of Action issued.

2. Case Situations

a. Original MFBU has zero SOC; due to voluntary inclusion of an additional family member, MFBU has a $X SOC.

(1) Issue a Record of Health Care Costs form, MC 177S, for month in which voluntary inclusion is requested with $X SOC. List the newly added family member on the form as an eligible member and the original members as ineligible ("I.E."). Update Medi-Cal Eligibility Data System (MEDS) to include the newly added family member with $X SOC. Do not change the MEDS records for the original members.

(2) Issue a Notice of Action approving benefits for the newly added family member with $X SOC. Indicate that $X SOC will be for the entire MFBU the following month. (This can be accomplished on a single notice or two separate notices can be used.) A ten-day advance notice is not required. Update MEDS records for following month to show $X SOC for all members of the MFBU.

NOTE: If the addition of the family member occurs late in the month (after county cutoff), step 1 above may be repeated the month following the month of request for voluntary inclusion. By month three, however, the entire MFBU should appear on the MC 177S.

b. Original MFBU has $X SOC; due to voluntary inclusion of an additional family member, the MFBU has an increased SOC of $Y. The MC 177S for the month has not been sent to the Department.

(1) Retrieve the MC 177S issued to the original members of the MFBU. Change the SOC from $X to $Y and add the new MFBU member to the form. Update MEDS to include the newly added family member with $Y SOC. Update MEDS records for original MFBU to reflect $Y SOC.

(2) Issue a Notice of Action approving benefits for the newly added family member and indicating an increase in SOC for the entire MFBU.

c. Same situation as in b. except the MC 177S for the month for the original MFBU members has been sent to the Department.

(1) Issue an MC 177S for the month in which voluntary inclusion requested with ($Y-$X) as the SOC amount (example: the SOC for the original MFBU was $25, the increased SOC is $75; $50 would be listed on MC 177S). List the newly added family member on the form as an eligible member and list the original family members as "I.E.". Update MEDS to include the newly added family member with ($Y-$X) SOC. Do not change the MEDS records for the original members.

(2) Issue a Notice of Action approving benefits for the newly added family member with an SOC of ($Y-$X). Issue a second notice that effective the first of the following month the SOC for the entire MFBU will increase to $Y. A ten-day advance notice is not required. Update the MEDS record for the following month for the entire MFBU to reflect $Y SOC. (The record for the newly added family member will change from ($Y-$X) to $Y; the records for the original members will change from $X to $Y.)

NOTE: If the addition of the family member occurs late in the month (after county cutoff), the following month the original MFBU may be issued an MC 177S with $X SOC and the newly added member issued an MC 177S with ($Y-$X) SOC. By month three, however, the entire MFBU should appear on the same MC 177S with a $Y SOC.

12G -- PROVIDER'S RESPONSIBILITY WITH RESPECT TO SHARE-OF-COST COLLECTION

This section provides information regarding the share-of-cost process which will be helpful in answering questions from providers, county mental health staff, and California Children Services (CCS) staff.

1. Can a provider list services on the Record of Health Care Costs form (MC 177S) for which he/she does not plan to bill the beneficiary?

   In completing and signing the MC 177S, the provider is certifying that he/she has not received and does not anticipate payment of the services by a third party, including Medicare (i.e., he/she is not billing a person or entity other than the patient for the patient's services). The provider is prohibited from billing the Medi-Cal program for the cost of services listed on the form.

   The above activities fulfill Medi-Cal program requirements. Whether or not the provider actively pursues or receives collection of the share-of-cost amount from the beneficiary is outside the purview of the Medi-Cal program. Therefore, ultimately, an uncollected share of cost may be offset against other general sources of revenue received by a provider, such as a "bad debt" against his/her gross profit, a partial fulfillment of a Hill-Burton obligation, or Short-Doyle funding. The critical factor is that the provider is not billing a third party or the Medi-Cal program for the services used to meet the beneficiary's share of cost.

2. Can CCS repayment obligations be applied toward a Medi-Cal share of cost?

   As a rule, CCS payments are considered third-party payments; therefore, the services for which CCS payments are received cannot be applied toward the Medi-Cal share of cost. Occasionally, a family will be assessed a CCS "repayment obligation". When this occurs, the CCS program pays for the medical services up front, then establishes a repayment plan for the family to pay the program for a portion of the services received. The amount of the CCS repayment obligation may be applied toward the Medi-Cal share of cost for the month in which the services are received. (This situation should rarely occur. The CCS program will provide documentation of the repayment obligation plan.) Example: In January, a child has surgery ($10,000 total cost) which is paid through CCS funds. The family's repayment obligation established through the CCS program is $175 and the family will make monthly payments of $25 commencing in March. The $175 may be applied toward the family's January Medi-Cal share of cost as that is the month in which the services were received.

12H--SHARE-OF-COST CLEARANCE FOR INDIVIDUALS WITH A BENEFICIARY IDENTIFICATION CARD

1. Background

Effective September 1, 1994 counties with the exception of San Mateo, Santa Barbara, and Solano will have implemented the beneficiary identification card (BIC) system. The BIC system substitutes the on-line clearance of share of cost (SOC) for the manual MC 177 process described in Article 12A. Please note: the on-line system allows for SOC clearance by providers or counties through Medi-Cal Eligibility Data Systems (MEDS).

2. Provider SOC Clearance Process

Medi-Cal providers may clear SOC with a point of sale device, state-supplied personal computer software, vendor-supplied software or the Automated Eligibility Verification System. The process is described in the Inpatient/Outpatient Electronic Data Systems Corporation Bulletin No. 236 table of contents and pages 1, 2, and 3 which we have reproduced and are included for your information as pages 12H3, 12H4, 12H5, and 12H6.

3. County SOC Clearance Process

The county has been given the ability to clear SOC through MEDS. This function is needed to clear SOC for those beneficiaries that utilize non-Medi-Cal providers. This is a high level activity which most counties will restrict to few individuals and/or terminals. The instructions for this process have been developed and will be part of a future MEDS handbook revision. They are included for your information as pages 12H7 to 12H15.

ELECTRONIC DATA SYSTEMS CORP.

MEDI-CAL UPDATE

P.O. BOX 13029, SACRAMENTO, CA 95813-4029

Inpatient/Outpatient Bulletin 236 **June 1994**

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- Remove and replace: 100-20-1/2, -5 thru -7
- Remove: 100-24-23
- Insert: 100-24-23/24 (*new*)
- Remove and replace: 100-26-11/12
- Remove: 100-42-1 thru -12
- Insert: 100-42-1 thru -14 (*new*)
- Remove and replace: 100-47-5 thru -8
  100-54-3/4, -9 thru -14

Section 200
- Remove and replace: 200-70-1/2*
  200-90-17/18

Section 300
- Remove and replace: 300-35-17/18
  300-38-9/10

Section 400
- Remove: 400-40-1 thru -6
- Insert: 400-40-1 thru -18 (*new*)
- Remove and replace: 400-44-5/6
  400-46-5/6 *

Section 1000
- Remove: 1000-15-1 thru -8
- Insert: 1000-15-1 thru -10

* Pages updated/corrected due to ongoing provider manual revisions.

Please turn page over for Medi-Cal Hotlines and Change of Address form

Inpatient/Outpatient Bulletin 236 June 1994

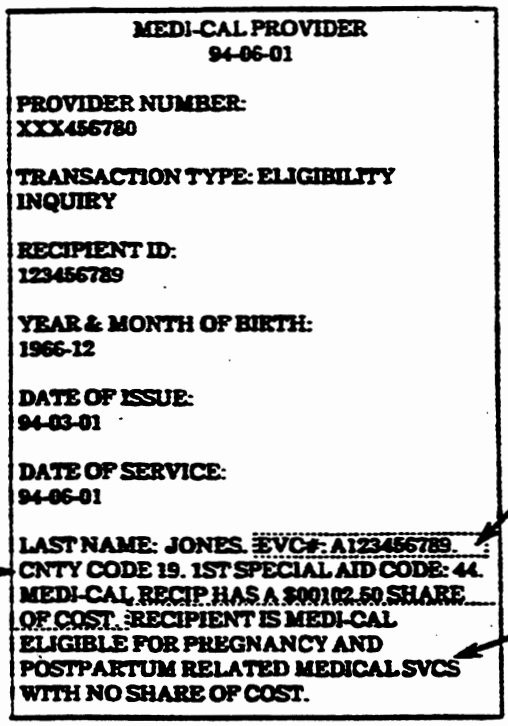
Verifying Recipient Eligibility: Multiple Messages

When verifying Medi-Cal eligibility, providers should be aware that more than one eligibility message will be returned for some recipients. The April 1994 bulletin announced that an Eligibility Verification Confirmation (EVC) number would not be returned from the Medi-Cal Host computer if the recipient had a Share of Cost (SOC) and also had eligibility under a special aid code for specific services with no SOC.

Effective June 1, 1994, system changes have been made to the POS network that will cause the Medi-Cal Host computer to return an EVC number to confirm eligibility for the specific services that do not have a Share of Cost.

The recipient in the example below (POS device printout) has a Share of Cost but is also eligible for pregnancy- and postpartum-related medical services without paying SOC.

Note: Claims and Eligibility Real-Time System (CERTS) software, telephone Automated Eligibility Verification System (AEVS) and Digital AEVS will return eligibility messages with wording similar to that of the POS device.



POS Device Printout

In the example above, if the service is related to pregnancy or postpartum, the provider would bill Medi-Cal and must not bill the recipient or collect (or obligate) an SOC payment. Only if the service is not related to pregnancy or postpartum would the provider collect (or obligate) an SOC payment.

POS Device and/or CERTS Software

Providers who have not already done so should act now to order a POS device and/or CERTS software by completing the *POS Network Enrollment Package* and mailing it to the EDS POS Help Desk. If you do not have an enrollment package, please call the EDS POS Help Desk at 1-800-427-1295 immediately.

BIC Implementation

Medi-Cal recipients in Colusa, Glenn and San Joaquin counties will begin using plastic Benefits Identification Cards (BICs) on July 1, 1994. Paper Medi-Cal ID cards will no longer be issued for these recipients, except for immediate need and minor consent recipients. Providers must verify eligibility of recipients with a BIC for every month of service. Eligibility verification, Share of Cost clearance and Medi-Service reservation can be performed by using a State-supplied POS device, State-supplied personal computer software (CERTS), vendor-supplied software or the Automated Eligibility Verification System (AEVS). Providers will need to know their Medi-Cal Provider Identification Number (PIN) to verify eligibility.

POS Device and Responses

The Point of Service (POS) device is easy to use, allows immediate access to eligibility information and is free to providers who have a volume of 300 claim lines adjudicated per year (for primary care providers) or 1,000 claim lines adjudicated per year (for other, non-pharmacy providers). If a Medi-Cal or CMSP recipient presents a plastic Benefits Identification Card (BIC) or one of the new paper cards, all providers statewide can perform the following transactions through the POS network:

- Eligibility verification
- Share of Cost
- Medi-Service

Providers are encouraged to apply for a free POS device or CERTS software by calling the EDS POS Help Desk at 1-800-427-1295. The telephone Automated Eligibility Verification System (AEVS) is designed for providers who see a small number of Medi-Cal or CMSP recipients.

Response Discrepancies

Some providers have reported receiving different results when manually inputting information rather than swiping the Benefits Identification Card (BIC) through the POS device. This may occur when there is an error in keying the recipient's number or when any information on the face of the BIC (including the ID number) has changed, but the recipient has not received a new BIC. When the BIC is swiped through the POS device, the recipient information returned from the Host is the most current and correct.

If you notice a discrepancy between the information on the face of the card and the information received, please verify that the identification number was entered correctly. Ask the recipient if any information on the face of the card has changed and whether the recipient has a more recent BIC. If a more recent card has not been received and the information on the face of the card has changed or is incorrect, the recipient should contact the local County Welfare Department.

VERIFYING RECIPIENT ELIGIBILITY: MULTIPLE MESSAGES (continued)

This policy applies to all recipients who have multiple eligibility messages, where one message indicates that the recipient has a Share of Cost and the other message(s) indicate the recipient is eligible for certain specific services.

If the recipient has an SOC, the message returned from the Host will contain language in the same sentence indicating that the recipient has an SOC and the dollar amount. For example:

> "Medi-Cal eligible limited to emergency and pregnancy related services with a Share of Cost of _____ dollars."

If you provide a service for which the eligibility message states the recipient is eligible for certain specific services and does not state that the recipient has an SOC in the same sentence, do not bill the recipient or collect (or obligate) the Share of Cost for that service. Bill Medi-Cal instead.

If you are unsure of the meaning of any responses you receive from the POS network, call the EDS POS Help Desk at 1-800-427-1295.

AEVS Improvements

Effective June 1, 1994, the Automated Eligibility Verification System (AEVS) will repeat the information that was entered (recipient ID number, date of birth and date of service) if the Medi-Cal Host computer returns a "No recorded eligibility for (month) (year)" message when verifying recipient eligibility. This improvement to AEVS will allow providers to verify that the correct information was entered.

For example, if the date of birth was incorrectly entered as 12/1936 instead of 12/1963, the Host would return the following message:

> "No recorded eligibility for June 1994 for recipient 123456789 with a date of birth of December 1936. To hear this information again, press 1. Otherwise, press 2."

An additional change to AEVS is that the Eligibility Verification Confirmation (EVC) number will now be returned at the end of the eligibility message. For example, you might hear the following message:

> "The first six letters of the recipient's last name are J O H N S O.
> The recipient's first initial is M.
> The county code is 19.
> The first special aid code is 76.
>
> Medi-Cal recipient has a Share of Cost of one-hundred-two dollars and fifty cents.
> Recipient is Medi-Cal eligible for pregnancy- and postpartum-related medical services with no Share of Cost.
>
> The Eligibility Verification Confirmation number is A123456789."

These changes are illustrated on manual replacement pages 100-54-3, -10, -11 and -14, included with this bulletin.

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CMC Technical Manual Revised

To prepare vendors, suppliers and billers for the *UB-92 Claim Form* conversion, EDS will be mailing the revised *CMC Technical Manual* in June. This manual will include the three electronic billing options available to bill Medi-Cal following the conversion. This information is being released in June to allow sufficient time to update billing programs.

The revised *CMC Technical Manual* includes:

- Medi-Cal 15-1 (*Outpatient*) and 16-1 (*Inpatient*) Formats—The current CMC formats will continue to be accepted after the conversion. Print program software must be modified to print the UB-92 format. (see *Section 100, CMC Data Specifications.*)

- American National Standards Institute (ANSI) 837 Format—The CMC ANSI X12 837 transaction record format described in *Section 120, CMC ANSI ASC X12 837—Data Specifications*, meets Medi-Cal claims processing requirements. Data elements included in the specifications are required for either ANSI standard transactions or Medi-Cal claims processing.

- Version 4 Flat File Format—The electronic Version 4 Flat File format used to bill Medicare also can be used to submit Medi-Cal inpatient and outpatient claims. (See new *Section 140, Electronic Version 4 Flat File—Data Specifications).*

Ordering Technical Specifications

ANSI and Version 4 Flat File format specifications are available by using the Medi-Cal Bulletin Board System (BBS) or ordering a printed copy of the *CMC Technical Manual*.

- Medi-Cal Bulletin Board System (BBS)—Technical specifications for the ANSI and Version 4 Flat File formats can be downloaded from the Medi-Cal Bulletin Board System (BBS). Refer to "Medi-Cal Bulletin Board System Instructions" on a following page for further information on accessing these formats.

- CMC Technical Manual—Providers interested in ordering a printed copy of the *CMC Technical Manual* should call the CMC Help Desk at (916) 636-1100.

  Note: Providers who were mailed the draft specifications in November do not have to call the CMC Help Desk to order a printed copy. EDS will directly mail the revised *CMC Technical Manual* in June.

Medi-Cal Bulletin Board System (BBS) Instructions

To access the Medi-Cal Bulletin Board System (BBS) and download the *CMC Technical Manual* files, please follow these instructions:

1. Call the CMC Help Desk at (916) 636-1100 and establish your BBS ID. (Identify yourself as either a Medi-Cal provider or a non-provider. If you are a Medi-Cal provider, your BBS ID will be your Medi-Cal Provider Number.)
2. After your BBS ID has been established, you may access the BBS by dialing (916) 636-1991. The BBS requires your communication program to be set for –No Parity, 8 data bits, 1 stop bit, ANSI Terminal Emulation. The BBS supports the X, Y and Z modem file transfer protocols.
3. To log on to the BBS you will need to respond to the initial "login" and "password" prompts. Type the login id "cawebbs" after the login: prompt and press <ENTER>. Type "cammis" after the password prompt and press <ENTER>.
4. The first BBS screen is the BBS Introduction Screen. Respond to the prompt asking about extended graphics character support by pressing the letter "Y" or "N" as appropriate for your computer.

SOCO - Share of Cost Obligation

PURPOSE

The SOCO screen allows the county the option of sending a transaction to DHS to obligate the Share of Cost for a recipient. This screen allows the county to perform similar online real-time SOC obligation transaction functions available to providers.

USAGE CONSIDERATIONS

- A Share of Cost record must exist on the Share of Cost Database.
- If the SOCO transaction results in the full obligation of the SOC, DHS will generate a SOC certification transaction.

SCREEN FORMAT

```
 SOCO                  ** SHARE OF COST OBLIGATION **          opr - mm/dd/yy
                                                                hh:mm:ss
 CASE-NAME ..................  DISTRICT ...          EW-CODE ....

 COUNTY-ID-PER-MEDS __ __ _______ _ __              SOC-FBU ..

 MEDS-ID _________              BIRTHDATE _______

 SERVICE DATE ______

 TOTAL-BILL-AMOUNT $ ______ . __

 AMOUNT-OBLIGATED  $  _____ . __                    REVERSAL-IND .

 PROVIDER MEDI-CAL NUMBER/LICENSE NUMBER _________

 PROCEDURE/DRUG CODE ...........
          ____

 NEXT-TRANS ....            SAME-PERSON .           SAME-CASE .
```

SOC0

DATA ELEMENTS	REQUIRED/ OPTIONAL	ENTRY ACTIONS
1. CASE-NAME	Optional	Enter the case name using up to 18 alphanumeric characters.
2. DISTRICT	Optional	Enter the district codes using up to 3 alphanumeric characters.
3. EW-CODE	Optional	Enter the eligibility worker code using up to 4 alphanumeric characters.
4. COUNTY-ID-PER-MEDS	Required	Enter the 14 digit county identification number for the recipient for which the SOC is being obligated.
5. SOC-FBU	Optional	Enter the 2 digit code your county uses to designate SNEEDE mini budget units. EXAMPLE: If your county assigns a numeric 1 as the FBU for all of its cases use the SOC-FBU as follows: FBU / SOC-FBU Mini 1 1 / 1A Mini 2 1 / 1B Mini 3 1 / 1C NOTE: This field is only used if the SOC case can not be uniquely identified with the County Code + Serial + FBU.
6. MEDS-ID	Required	Enter the recipient's Social Security Number or the MEDS pseudo number.
7. BIRTHDATE	Required	Enter the recipient's birthdate per MEDS using 7 digits in the format MMDDYYY.
8. SERVICE-DATE	Required	Enter the date the Medical Service was provided.
9. TOTAL-BILL-AMOUNT	Required	Enter the total dollar amount of the Medical Service provided in dollars and cents.
10. AMOUNT-OBLIGATED	Required	Enter the total dollar amount that the recipient has obligated toward the SOC amount in dollars and cents.
11. REVERSAL-IND	Optional	Enter an X if this is a SOC Obligation reversal.

DATA ELEMENTS	REQUIRED/ OPTIONAL	ENTRY ACTIONS
12. PROVIDER-MEDI-CAL-NUMBER/ LICENSE-NUMBER	Required	Enter the PROVIDER-MEDI-CAL-NUMBER/ LICENSE-NUMBER if available. If the number is not available leave blank.
13. PROCEDURE/DRUG-CODE	Optional	Enter the PROCEDURE/DRUG-CODE if available. If the procedure code is not available leave blank.
14. NEXT-TRANS	Future Use	
15. SAME-PERSON	Future Use	
16. SAME-CASE	Future Use	

SOCR - SOC CASE MAKE-UP INQUIRY REQUEST

PURPOSE

The SOCR screen is the inquiry screen that provides access to the online real-time Share of Cost Database. The SOC database contains up to the minute information on all cases reported to MEDS with a SOC.

USAGE CONSIDERATIONS

- The VALID-MMYY is the month of eligibility for which the inquiry is made.
- When the SOC-CASE-ID is entered, the case make-up (members of the specified case) is displayed on the SOCI screen.
- When the MEDS-ID is entered a list of all SOC cases that the recipient is a member, will be displayed. Select the specific case to perform a case make-up inquiry. When the specific case is chosen, the SOCI screen is displayed providing detailed information about the members of that case.

NOTE: Lines 12-23 will only be displayed if multipe SOC cases are found.
If a single SOC case is found, the SOCI screen will be displayed.

SCREEN FORMAT

```
SOCR            ** SOC CASE MAKE-UP INQUIRY REQUEST **          opr - mm/dd/yy
                                                                      hh:mm:ss

VALID-MMYY ____


SOC-CASE-ID: COUNTY __  SERIAL _______  FBU (OPT) _  SOC-FBU (OPT) __
    OR
  MEDS-ID:   ___ __ ____


MULTIPLE SOC CASES WERE FOUND, SELECT ONE SOC-CASE-ID FROM THE LIST BELOW:

  _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)
  _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)
  _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)
  _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)
  _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)
  _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)
  _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)
  _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)
  _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)
  _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)     _ cc-sssssss-f (sf)
```

NOTE: Lines 12-23 will only be displayed if multiple SOC cases are found. If a single SOC case is found, the SOCI screen will be displayed.

	DATA ELEMENTS	REQUIRED/ OPTIONAL	ENTRY ACTIONS
1.	VALID-MMYY	Required	The date should be in the format MMYY, for the month of inquiry.
2.	SOC-CASE-ID:	Optional	Enter the 9 digit county indentification number in the following format:
	COUNTY		COUNTY NN
	SERIAL		SERIAL NNNNNNN
	FBU	Optional	When the complete SOC-CASE-ID (COUNTY + SERIAL + FBU or SOC-FBU) is entered, you will go directly to the SOCI screen. When a partial SOC-CASE-ID (minimum is COUNTY and SERIAL) is entered, you will get a list of all cases that match that partial ID. If there is only 1 case, associated with that partial ID, you will go directly to the SOCI screen.
	or		
	SOC-FBU	Optional	
5.	MEDS-ID	Optional	Enter the recipients's Social Security number or the MEDS pseudo number. When MEDS-ID is entered, all of the SOC cases associated with that MEDS-ID will be displayed. Select the specific case and bring up the SOCI and the case members. If you enter a MEDS-ID which is associated with 1 SOC case you will go directly to the SOCI screen.

NOTE: The SOC-FBU is only used if the SOC case cannot be uniquely identified with the COUNTY + SERIAL + FBU.

SOCI - Share of Cost Case Make-up Inquiry

PURPOSE

The SOCI displays detailed information for all members of the Share of Cost case requested on the SOCR. The information displayed on the SOCI screen is located on on the SOC Database. Because the SOC Database uses a unique SOC-CASE-ID, inquiries must be made on the SOCR screen.

USAGE CONSIDERATIONS

- The data displayed on the SOCI screen is based on up to the minute information from the SOC Database.
- The SOCI screen shows the SOC case amount and the SOC Balance (the amount of SOC obligation remaining for the inquiry month).
- The SOC Database will contain the current month and 15 prior months of SOC information.

SCREEN FORMAT

```
| SOCI              ** SHARE OF COST CASE MAKE-UP INQUIRY **       opr - mm/dd/yy |
|                                                                       hh:mm:ss |
| SOC-CASE-ID xx-xxxxxxx-x (xx)  SOC $xxxxx  BALANCE $xxxxx.xx  VALID-MMYY xx/xx |
|                                                                                |
| ----------------------------- SOC CASE MEMBERS ------------------------------ |
|  MEDS-ID         COUNTY-ID           BIRTHDATE    NAME                         |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
| xxx-xx-xxxx   xx-xx-xxxxxxx-x-xx    xx/xx/xxxx   xxxxxxxxxxxxxxx, xxxxxxxxxx x |
|                                                                                |
```